EMPLOYEE BENEFIT GUIDE

January 1, 2011 – December 31, 2011

2011 BENEFITS AT A GLANCE

INTRODUCTION

The City of Frisco (City) is pleased to provide you with a Benefits Program designed to safeguard your financial health care needs.

Coverage is scheduled to begin January 1, 2011 or, if hired after January 1, 2011, on the first day of the month following 31 days of employment.

Your coverage will end at midnight on the last day of employment or when you are no longer eligible for the plan. If you wish to continue your Medical, Dental, and/or Vision coverage, you may do so through COBRA by completing an election form and paying the appropriate premiums. *See COBRA Notice on page 10 for COBRA coverage information.*

When is the 2010 Open Enrollment?

Open enrollment period for plan year 2011 is from October 1, 2010 through October 29, 2010. All forms are to be returned to HR no later than noon on ***Friday, October 29, 2010***. During this time, you may add or drop dependents. You will also be able to add, remove or change your coverage.

When are the Open Enrollment Meetings?

Open enrollment meetings (mandatory attendance) regarding 2011 benefit changes will be held during the following days at various times:

Date	Time	Location	
Friday 10/1/10	7:00 a - 9:00 a	Parks Departments	6726 Walnut Street
	4:30 p - 6:30 p	Police Department Training Room	7200 Stonebrook Pkwy
Monday 10/4/10	7:30 a - 9:30 a	Public Works Training Room	11300 Research Rd
	2:00 p - 4:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Tuesday 10/5/10	8:00 a - 10:00 a	Central Fire Station Training Room	8601 Gary Burns Dr
	1:00 p - 3:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Wednesday 10/6/10	7:00 a - 9:00 a	Parks Departments	6726 Walnut Street
	1:00 p - 3:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Thursday 10/7/10	7:00 a - 9:00 a	Parks Departments	6726 Walnut Street
	1:00 p - 3:00 p	Central Fire Station Training Room	8601 Gary Burns Dr
Monday 10/11/10	9:30 a - 11:30 a	Police Department Training Room	7200 Stonebrook Pkwy
	2:00 p - 4:00 p	Central Fire Station Training Room	8601 Gary Burns Dr
Tuesday 10/12/10	8:00 a - 10:00 a	Central Fire Station Training Room	8601 Gary Burns Dr
	1:00 p - 3:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Wednesday 10/13/10	8:00 a - 10:00 a	Central Fire Station Training Room	8601 Gary Burns Dr
	1:00 p - 3:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Thursday 10/14/10	7:30 a - 9:30 a	Public Works Training Room	11300 Research Rd
	1:00 p - 3:00 p	George A. Purefoy Municipal Center	6101 Frisco Square Blvd Council Chambers
Friday 10/15/10	7:30 a - 9:30 a	Public Works Training Room	11300 Research Rd
	3:00 p - 5:00 p	Police Department Training Room	7200 Stonebrook Pkwy

Annual Benefits Enrollment
Don't be late! Submit your benefits enrollment by the deadline!

What's New for 2011

Below is a list of changes effective January 1, 2011. You will find more information about each benefit carrier on the following pages.

- New **Medical Plan** carrier: - Changing from Healthsmart to United Healthcare (UHC).
- New **Life** carrier - Changing from Fort Dearborn to UNUM.
- New **Long Term Disability** carrier - Changing from The Standard to UNUM.
- New **Short Term Disability** carrier - Changing from The Standard to UNUM.
- New **Flexible Spending Account (FSA)** carrier - Changing from PayFlex to United Healthcare (UHC).
- New **Employee Assistance Program (EAP)** carrier - Changing from MHN to UNUM.
- The **Long Term Care (LTC)** benefit will no longer be offered through the city. Employees will need to contact Prudential to make arrangements to pay them directly.

What's Staying the Same for 2011

Great news! Employee contribution rates are staying the same on all of the benefit plans! The following carriers are staying the same for the 2010 plan year:

- Vision Plan - VSP
- Dental PPO Plan – Delta Dental
- Dental DHMO Plan – Assurant Employee Benefits

ID Cards

You will receive new ID cards for the Medical/Rx, Dental DHMO plans, and Vision plans. You will need to go to www.deltadentalins.com to print ID cards for the Delta Dental DPPO plan. HR department will keep a supply of Vision ID cards on hand throughout the year. Please start using your new ID cards after December 31, 2010 and discard any of your old ID cards.

FSA Claims

If you have not filed your FSA claims by December 31, 2010, you will need to submit all future claims (regardless of the incurred date) to United Healthcare (UHC) starting January 1, 2011. Please refer to page 10 for FSA reimbursement methods.

Medicare Part D
NOTE: If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 15 for more details.

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TAXES AND YOUR BENEFITS

Your cost for many of the coverages under the Benefits Program will be paid on a before-tax basis through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

Plan	Who Pays the Cost?	Is Your Cost Before Tax or After Tax?
Medical - United HealthCare (UHC)		
Employee	The City/You	No Cost/Before Tax
Dependent	You	Before Tax
Dental DPPO - Delta Dental		
Employee	The City/You	No Cost/Before Tax
Dependent	The City/You	Before Tax
Dental DHMO - Assurant Employee Benefits		
Employee	The City/You	Before Tax
Dependent	You	Before Tax
Vision - Vision Service Plan (VSP)		
Employee	You	Before Tax
Dependent	You	Before Tax
Basic & AD&D Life Insurance - Unum		
Employee	The City	No Cost
Supplemental Life Insurance - Unum		
Employee	You	After Tax
Dependent	You	After Tax
Long Term Disability - UNUM		
Employee	The City	No Cost
Short Term Disability - UNUM		
Employee	You	After Tax
Work-Life Balance Employee Assistance Program - UNUM		
Employee	The City	No Cost
Dependent	The City	No Cost
Flexible Spending Account - United Healthcare (UHC)		
Health Care	You	Before Tax
Dependent Care	You	Before Tax

PAYROLL CONTRIBUTIONS

When you elect optional benefits under the Benefits Program, you make a payroll contribution toward the cost of this coverage. Contributions for other optional benefits are based on the level of coverage you select and in some cases, your age, your earnings, and/or your tenure.

If you elect medical, dental, or vision insurance coverage, you are automatically enrolled in the Section 125 Plan. One of the limitations the IRS places on the Plan is that once coverage takes effect, you cannot drop or change the coverage until the Plan's annual enrollment unless you have a qualifying change in family status.

Contributions for Employees Effective January 1, 2011

Coverage costs are paid on a pre-tax basis through the first two pay periods of each month for a total of 24 deductions from 26 paychecks.

United Healthcare (UHC) Choice Plus PPO Plan Deductible*
(Full-time employees)

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
Emp Only	$562.00	$535.00	$27.00	$13.50
Emp + Sp	$1,067.00	$727.00	$340.00	$170.00
Emp + Ch	$899.00	$567.00	$332.00	$166.00
Emp + Fam	$1,404.00	$798.00	$606.00	$303.00

United Healthcare (UHC) Choice Plus PPO Plan No Deductible*
(Full-time employees)

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
Emp Only	$618.00	$577.00	$41.00	$20.50
Emp + Sp	$1,174.00	$807.00	$367.00	$183.50
Emp + Ch	$988.00	$649.00	$339.00	$169.50
Emp + Fam	$1,544.00	$903.00	$641.00	$320.00

Delta Dental DPPO Plan*

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
Emp Only	$20.64	$14.24	$6.40	$3.20
Emp + Sp	$38.98	$26.12	$12.86	$6.43
Emp + Ch	$48.16	$32.28	$15.88	$7.94
Emp + Fam	$66.50	$44.56	$21.94	$10.97

Assurant Employee Health Dental HMO Plan*

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
Emp Only	$12.88	$8.50	$4.38	$2.19
Emp + Sp	$21.94	$15.36	$6.58	$3.29
Emp + Ch	$28.96	$20.28	$8.68	$4.34
Emp + Fam	$37.00	$25.90	$11.10	$5.55

Vision Service Plan (VSP) Vision Plan

Tier	Monthly Rate	City Portion	Employee Portion	Per Pay Period
Emp Only	$4.56	$0.00	$4.56	$2.28
Emp + Sp	$8.54	$0.00	$8.54	$4.27
Emp + Ch	$9.10	$0.00	$9.10	$4.55
Emp + Fam	$14.18	$0.00	$14.18	$7.09

UNUM Group Life Insurance

The City pays 100% of employee coverage.

UNUM Group Long Term Disability Insurance

The City pays 100% of employee coverage.

UNUM Voluntary Short Term Disability Insurance

You pay 100% of your coverage.

**Your deductions for medical, dental, and/or vision coverage are made on a pre-tax basis. This reduces your taxable income and saves on federal, social security, and most state income taxes.*

YOUR BENEFITS PROGRAM

The City offers a comprehensive, cost-effective, and competitive benefits package. This package helps to protect you and your family, but it works only if you take control and make thoughtful decisions about your benefits.

You have an active role in choosing your benefits coverage. This way, your benefits line up with your individual needs and goals.

The City provides you with several tools, including this Employee Benefits Guide, to help you make your benefits selections. **Be sure to enroll before your deadline** so you can get the maximum value from these plans and programs for yourself and your family.

Who is Eligible?

You are eligible to enroll in the City's Benefits Program if:

- You are a regular, full-time employee of the City.
- You are a part-time employee who is budgeted to work 30 hours a week.
- Retirees who retire through TMRS.

Who are My Eligible Dependents?

You may cover your lawful spouse and dependent children. Dependent children include stepchildren, grandchildren if the employee has legal guardianship, adopted children and children placed for foster care. Children are eligible to age 26. A child who is physically or mentally handicapped may be eligible for coverage at any age as long as the disability takes place before the limiting age.

What Happens if I Fail to Enroll?

This is your opportunity to select the coverage appropriate for both you and your qualified dependents. You must make your initial enrollment selections within 31 days of your date of hire (or eligibility date for newly benefits eligible employees). If you fail to enroll within the 31-day enrollment period, you waive your rights to enroll in these plans until the next Open Enrollment period or until you have a qualified life event.

Can I Change My Coverage During the Year?

Once you have made your benefit elections, you generally cannot change them during the year. However, you may make certain changes if you have a qualified change in family status that affects your benefits. Typical family status changes include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or eligible dependent
- Enrollment in (or loss of) state or federal medical coverage
- A change in your spouse's employment insurance coverage
- A child no longer qualifies as a dependent due to age.

You must notify Human Resources of any family status change within 31 days of the date that the family status change occurred. If you wait longer than 31 days, you will not be allowed to change or drop any coverage until the next annual enrollment – this is an IRS rule.

MEDICAL AND RX COVERAGE

Medical Benefits to Keep You Healthy

The medical plan will be administered by United HealthCare (UHC). Your medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The medical plan provides you with coverage, depending on the medical provider that you use.

> Your medical plan pays the highest benefits when you use in-network providers.

You have the option to choose from two medical plans offered by UHC – Choice Plus PPO Plan Deductible or Choice Plus PPO Plan No Deductible.

To keep you in control of your health care decisions, UHC plans give you the freedom to see any doctor in the network, including specialists, without a referral. You can even visit any out-of-network physician and still enjoy your benefits with somewhat higher deductibles and copayments.

With UHC PPO plans, the majority of your health care needs are covered with little or no out-of-pocket costs when you visit a network doctor or facility. Plus, when you visit network doctors and hospitals, there aren't any claim forms to worry about.

Preferred Provider Organization (PPO) Plan

A PPO network of health care providers are contracted to provide medical services to covered employees and dependents at negotiated rates. You may receive care from either a network or non-network provider, but network care is covered at a higher benefit level and the employee is responsible for a greater portion of the cost when using a non-network provider. For example, LabCorp is a network lab while Quest is out-of-network. Make sure your doctor utilizes in-network labs.

> Remember to check and see if your lab is in-network. This way you will receive the in-network benefit.

Coordination of Insurance Benefits

Your City benefits coordinate with those benefits you or your spouse may be entitled to receive from other plans. This prevents duplication of payment if you or your dependents are covered by another insurance plan. The plan that covers an individual as an Employee is always the primary plan for that individual. In other words, your City medical plan will always be primary for you. If your spouse is covered elsewhere, that plan becomes primary for him or her. Either you or your working spouse, or both, may cover your eligible dependent children under your respective employer's plan. If both parents work for the City then only one parent can cover the children. If a child and parent both work for the City, the child must enroll as an employee and not a dependent. If the children have coverage under more than one plan, benefits will be coordinated according to the rules of each plan. This plan uses the "Birthday Rule," which means that the parent whose birthday (month and day) comes first in the year will be the primary payer. You can update your coordination of benefits information at www.myuhc.com or by contacting Customer Service at 1-800-842-5658.

Remember to enroll your newborn within **31** days from the date of birth.

www.myuhc.com

www.myuhc.com makes managing your personal health and benefits easy and convenient. Learn about health conditions, treatments, and costs; check claims status; find a provider; print a temporary ID card or request a replacement ID card; or use Pharmacy Online to order and renew prescriptions. It's all online and at your fingertips just by registering at www.myuhc.com.

NurseLine

The NurseLine provides immediate access to experienced registered nurses- 24 hours a day, seven days a week. Simply call 1-800-846-4678. The nurses can help you find a doctor or hospital, help you understand treatment options, answer your medical questions and help you choose appropriate medical care. This is an absolutely FREE service to you!

UnitedHealth Premium Designation Program

Do you need to find a new doctor or specialist but don't know where to begin? Are you curious how your doctor rates among his peers? UnitedHealth Premium Designation Program evaluates and recognizes physicians whose practices are consistent with quality and cost-efficiency national medical standards such as the American College of Cardiology, The Ambulatory Care Quality Alliance, and The Agency for Healthcare Research and Quality. The designated doctors may have lower surgery repeat rates, follow evidence-based guidelines for care, and are more likely to be aware of the latest research and clinical trials.

Healthy Pregnancy Program

Do you have questions or concerns about your current pregnancy? The Healthy Pregnancy Program provides 24-hour toll-free access to experienced nurses by calling 1-800-411-7984 or visiting www.healthy-pregnancy.com. The nurses can help identify your risks and special needs, provide you with pregnancy and childbirth education materials and resources, and there are **FREE** gifts and savings for the mother and baby!

Rx Benefits

The Rx plan will be administered by United HealthCare (UHC). Your Rx benefits provide you with both retail and mail order prescription drugs. Your copays are $15 for tier 1 (generally generic prescriptions), $25 for tier 2 (generally brand prescriptions), and $50 for tier 3 (generally brand prescriptions).

Mail Order Pharmacy

Using the Medco Pharmacy, a national distribution network, mail order efficiently and safely provides you with the medications you need. Using mail order eliminates the need for you to travel to a retail pharmacy for medications you take on an ongoing basis. And since dispensing usually covers a three-month supply, fewer refills are required throughout the year.

Mail order can drive down costs through:

- Deeper discounts off the average wholesale price for many medications
- No dispensing fees
- Improved brand to generic substitution rates
- Greater compliance with drug utilization and safety rules

Transitioning to the Mail Order Pharmacy

When your doctor prescribes a new medication you will be taking on an ongoing basis, be sure to request two (2) prescriptions. The first prescriptionshould be for a one-month supply and filled at your participating retail pharmacy. The second prescription, for a 90-day supply with refills, should be filled at the mail order pharmacy. This will help you start your new medication right away and without a delay in starting your new medication.

To transfer prescriptions from your retail pharmacy to the mail order pharmacy, simply choose an option below:

1. Call the number on your ID card. Ask Medco to contact your doctor to fill your new 90-day prescription through the Medco Pharmacy.

2. Mail your prescription to Medco. If you'd prefer to send your prescription by mail, go to the Web site listed on your ID card and download an order form. Then mail it with your prescription to the address provided.

3. Ask your doctor to do it. Ask your doctor's office to call 1 888-EASYRX1 (1-888-327-9791) for instructions on how they can fax your prescription to the mail order pharmacy. Your doctor should write your prescription for a 90-day supply with refills when appropriate (not a 30-day supply with three refills). You will be charged a mail order copayment regardless of the days supply written on the prescription. Remember to provide your doctor's office with the member number on your ID card.

The UnitedHealthcare Specialty Pharmacy Program

Specialty medications are critical to improving the health and lives of individuals - and are also some of the most expensive medications being used today. UHC wants to make these medications accessible and affordable for you and the City.

What is a specialty medication?

UHC defines specialty medications as having one or more of the following attributes:

- Cost greater than $250 per prescription
- Frequently administered by injection or infusion
- Treats rare, unusual or complex diseases
- Requires additional clinical oversight and expertise for best management

What is a Specialty Pharmacy?

UHC has created a network of select specialty pharmacies based on their level of clinical capabilities, quality of services, and medication cost. Using specialty pharmacies is beneficial because they have the experience in storing, handling, and distributing these unique medications.

They also typically provide a higher level of customized care than traditional retail pharmacies. Specialty pharmacists and nurses have additional clinical expertise on the specialty medications and these unusual and complex diseases. These specialty pharmacies provide exceptional services that include:

- Accurate prescription dispensing and timely delivery.
- Pharmacists and licensed health care professionals available 24 hours a day to answer your questions about your medication or your specific health condition.
- Member education and care support services with development and monitoring of a care plan, if needed.
- Medication-related supplies, such as syringes, needles and disposal containers free of charge.
- Shipping to any location for no additional charge.
- Prescription shipments mailed in confidential, temperature-sensitive packaging.

How do I locate a Specialty Pharmacy?

Step 1: After receiving a prescription for a specialty medication, call the UHC Specialty Pharmacy Referral Line's toll-free telephone number at 866-429-8177.

Step 2: The Specialty Pharmacy Referral Line representative will ask a few questions, verify your medication and then transfer you to an appropriate network specialty pharmacy based on your specific medication.

Step 3: The specialty pharmacy representative will answer questions you have and begin the process of working with you and your health care provider to fill your prescription and support your medication needs.

Using a network specialty pharmacy will ensure continuation of your network benefits. If you fill your specialty medication at a non-network pharmacy, you may have to pay more for your medication. Talk to Human Resources if you are unsure of how your specific pharmacy benefit works.

Using Network Providers makes
GOOD FINANCIAL SENSE!

Medical Plan Highlights

UHC Choice Plus PPO Plan Deductible		
Features	**In-Network**	**Out -of-Network Only**
Annual Deductible	$250 $500	$500 No family deductible
Annual Out-of-Pocket Maximum	$2,750 $5,500	No maximum No maximum
Co-Insurance	80%	60%
Lifetime Maximum	Unlimited	Unlimited
Wellness Services	$25 copay	Not Available
Office Visits	$25 copay PCP* $30 copay SPC**	60% after ded***
Hospital Inpatient	80% after ded	60% after ded***
Outpatient Surgery	80% after ded	60% after ded***
Urgent Care	$30 copay	60% after ded***
Emergency Room True Medical emergencies will be covered at any hospital	$75 copay and then 80%	$75 copay and then 80%
Prescription Drugs - Retail (31 days)	$15 / $25 / $50	$15 / $25 / $50
Prescription Drugs - Mail Order (90 days)	$30 / $50 / $100	N/A

UHC Choice Plus PPO Plan No Deductible		
Features	**In-Network**	**Out -of-Network Only**
Annual Deductible	No deductible No deductible	No deductible No deductible
Annual Out-of-Pocket Maximum	$1,750 $3,500	No maximum No maximum
Co-Insurance	90%	60%
Lifetime Maximum	Unlimited	Unlimited
Wellness Services	$25 copay PCP* $30 copay SPC**	Not available
Office Visits	$25 copay PCP* $30 copay SPC**	60% after ded***
Hospital Inpatient	$150 copay per day (max of 4 copays)	60% after ded***
Outpatient Surgery	$300 copay	60% after ded***
Urgent Care	$30 copay	60% after ded***
Emergency Room True Medical emergencies will be covered at any hospital	$75 copay	$75 copay
Prescription Drugs - Retail (31 days)	$15 / $25 / $50	$15 / $25 / $50
Prescription Drugs - Mail Order (90 days)	$30 / $50 / $100	N/A

**PCP - Primary Care Physician*
***SPC - Specialist*
**** ded = deductible*
*****This is an overview of your benefits. The contract will govern actual benefits.*

Opt-Out of a Medical Plan

Provided you show valid proof of other comparable medical plan coverage, you may choose to Opt-Out of the City's medical plan. If you choose this option, you must provide proof of other comparable medical coverage *and* complete a "Certification of Other Comparable Coverage" form. Both documents must be received by the City's Human Resources Department before the enrollment deadline. If you do not provide a Certification of Other Coverage Form, or if your proof of coverage is found to be invalid, the City can enroll you in the PPO plan, employee only coverage.

Complete a Certification of Other Coverage form! The form is located on page 19.

If you select Opt-Out you are considered "absent" from the medical plans. You are not eligible for continuation of medical coverage (COBRA) if you elect to Opt-Out of medical coverage.

Make sure you provide current valid "proof" of your comparable medical coverage during annual enrollment. Examples of other coverage that cannot be used to Opt-Out of the City's medical plan include Tri-Care "supplemental"coverage, student insurance or medical payments coverage provided as part of your auto insurance policy. The City will confirm your other coverage. Check with Human Resources if you have questions.

Retiring soon? If you are an Opt-Out member contemplating retirement, you may want to reconsider your Opt-Out status during annual enrollment. Check with Human Resources for more details.

HELPFUL DEFINITIONS

- **Calendar Year** – January 1 through December 31 of each year.
- **Coinsurance** – The percent of eligible charges that the plan pays.
- **Copayment (Copay)** – The amount paid by a covered person to a network provider at the time service is rendered. Copayments for covered services are not applied to your deductible.
- **Deductible** – The amount you pay each calendar year before the plan begins to pay covered health care expenses.
- **Medical Emergency** – A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.
- **Network Benefits** – The benefits applicable for the covered services of a network provider.
- **Open Enrollment** – The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.
- **Out-of-Pocket Maximum** – The most a covered person will pay in deductibles and coinsurance in a calendar year for covered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and copays).

DENTAL COVERAGE

Dental Benefits to Keep You Smiling

The City offers two dental plans; one is a DHMO dental plan offered by Assurant Employee Benefits (Assurant) and the other is a DPPO plan offered by Delta Dental. The DHMO dental plan (Assurant) allows employees and their dependents to receive services performed by an Assurant general dentist at set copayments. The DPPO indemnity dental plan (Delta Dental) allows you to receive the same level of benefits whether you see a dentist who participates in the network or not, however, you may reduce your out-of-pocket expenses by using a provider that participates with Delta Dental.

Assurant Dental DHMO Plan Highlights

Employees will receive Evidence of Coverage with the ID card at their home. This information will include detailed information regarding the plan including the copayment schedule. During the enrollment process employees may contact the Employee Benefit Hotline at 1-800-443-2995 for assistance.

Will I Receive an ID card for my Assurant Dental DHMO Plan?

Yes. ID cards are ordered and shipped to the member's home address. This process will take 7 – 10 business days from the time Assurant receives the enrollment information. During this time frame, employees can contact Member Services for benefit verification and eligibility.

To access customer service, verify benefits or eligibility, or obtain a list of participating dentists, call Assurant at 1-800-443-2995 or visit www.assurantemployeebenefits.com.

Delta Dental PPO Indemnity Plan – Why Use Participating Dentists?

Utilizing participating PPO dentists can save you money and hassles. Participating dentists have agreed to accept negotiated fees that are typically 10% to 30% below community averages. This means your share of the cost is lower because the total bill is lower. In addition, you don't have to worry about getting billed for the balance later if the dentist's charges exceed the usual and customary charges. Both Delta Dental PPO dentists and Delta Dental Premier Dentists are considered in-network although you will save more money when you select a PPO dentist.

To access customer service, verify benefits or eligibility, or obtain a list of participating dentists, call Delta Dental 1-800-521-2651 or visit www.deltadentalins.com.

Will I Receive an ID card for my Delta Dental DPPO Plan?

No. ID cards are not required to visit a Delta Dental dentist. However, you may print one by logging in to www.deltadentalins.com and following the prompts. Human Resources can also provide you with a copy of the ID card.

Pre-Treatment Authorization

While Delta Dental does not require a pre-treatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it is best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pre-treatment estimate to Delta Dental. They will inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there will not be any surprises once the work is done!

Delta Dental Plan Highlights

Plan Feature	Value Plan	
	In Network	Out of Network
First You Pay a Calendar Year Deductible of:	$50 per individual $150 per family	
Then the Plan Pays:		
Preventive Services	100%	100%*
Basic Services	80%	80%*
Major Services	50%	50%*
Orthodontia Services	$1,750	
Calendar Year Maximum Benefits Per Person	$1,500	

**UCR - Usual & Customary*

Differences in the Dental Plans

Below is a summary of the major differences in the dental plans:

Features	Delta Dental	Assurant
Network Dentists	May be treated by dentist of choice	Must receive treatment from an Assurant network dentist
Annual Deductible	$50 per person (except for preventive & diagnosis)	No deductible, no claim forms
Dental Out of Pocket Expenses	Deductible/co-insurance apply	Co-payment depends on treatment received (co-pay schedule)
Orthodontia	Benefit allows $1,750 per person Lifetime maximum	Benefit is $2,000 co-payment per person under 19, Benefit is $2,200 co-payment per person over 19

VISION COVERAGE

Vision Benefits to Improve Your Sight

The City will continue to offer vision care services through Vision Service Providers (VSP) for you and your family. VSP provides affordable, quality vision care. You may choose from a wide selection of vision providers in the Frisco area and across the country.

Why Use Participating Vision Providers?

You may use a VSP network provider or another vision care specialist of your choice. To access network vision benefits, simply schedule an appointment with a VSP provider and identify yourself as a VSP member.

If you use a non-network provider, you may be required to pay for all expenses at the time services are rendered and will have to file a claim to receive reimbursement for any covered expenses.

Will I Receive an ID Card?

ID cards are not required to visit a provider. Members can log on to www.vsp.com and print a vision ID card from the website. Simply provide this ID card to your provider of services and they will contact VSP directly to verify benefits.

To access customer service, verify benefits or eligibility, or obtain a list of participating providers, call VSP at 1-800-877-7195 or visit www.vsp.com

Vision Plan Highlights

Features	In-Network	Out-of-Network
	Copay:	Reimbursement:
Eye Exam (Once every 12 months)	$30	Up to $43
Eyeglass Lenses (Once every 12 months)		
Single	Covered in full after copay	Up to $30
Bifocal		Up to $45
Trifocal		Up to $62
Lenticular		Up to $62
Eyeglass Frames (Once every 12 months)	$150 allowance	Up to $40
Contact Lenses * (Once every 12 months)	$200 allowance**	Up to $185

**In lieu of eyeglasses*
***Your $200 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses.*

WORK-LIFE BALANCE EMPLOYEE ASSISTANCE PROGRAM

Personal problems can affect the lives of employees both at home and at work. When life's events become challenging, we would like to remind all City employees about our Employee Assistance Program (EAP). The EAP program will supply professional counselors to counsel employees and their families per issue in a safe, private atmosphere – at no additional cost to the employee. The City's EAP cost is 100% paid for by the City, administered by UNUM and includes three (3) visits per condition annually.

Plan Features
Three (3) Confidential Counseling Services per Condition Annually plus
Financial and Legal Assistance

What Happens When You Call the EAP?

When you contact the EAP program, one of the counselors will conduct an assessment with you over the telephone to determine what services will best assist you. If a referral to a network provider is necessary, the assessment will include gathering your specific provider criteria such as location, day and time availability, and specialty. The network provider will conduct a face-to-face assessment at your first session. **All information disclosed will remain confidential.**

To access customer service, verify benefits or eligibility, or obtain a list of participating providers, call Work-Life Balance at 1-800-854-1446 or visit www.lifebalance.net.

What Types of Services are Offered through my EAP?

The City understands that everyone experiences periods of stress and that some stress is normal, but if your feelings become persistent and overwhelming it may be an indication of a serious medical problem. That is why we want to make you aware of all the resources available to you through the City's EAP program. These services are available to you:

- Face-to-Face Counseling
  - Marital and Family Relationships
  - Stress Management
  - Alcohol and Drug Issues
  - Work-Related Concerns
  - Depression and Anxiety
  - Bereavement
- Work Life Services
- Legal Services
  - Consultations
  - Referrals
- Financial Services
  - Consultations
  - Referrals

Financial Consultation

Personal concerns and daily living issues often have a corresponding financial component. The Work-Balance EAP program can connect employees with a financial consultant who can provide information and guidance on a wide range of issues.

How Does this Work?

This telephonic consultation is provided at no additional charge to the employee. When appropriate, the consultant can provide a local community referral or suggest other financial resources for a specific concern. The financial consultation offers employees proactive information and guidance for finance-related questions, as well as strategic action plans when dealing with more reactive financial problems. The financial consultant will review an individual's past history, examine the current situation and work with the individual to develop a financial plan or a resolution strategy.

Legal Consultation

Often when legal concerns arise, individuals do not know where to begin to get assistance. Often they do not have a family lawyer and are unsure of how to select a lawyer to assist them with a particular need.

How Does this Work?

Work-Balance's nationwide legal consultation and referral services normally provide a brief telephonic consultation. The goal of this consultation, which is provided at no additional charge, is to clarify legal issues that need to be addressed, and other pertinent information. When appropriate or requested, a referral may be made to a local attorney for specific concerns, with a 30 minute initial visit provided free of charge.

LIFE INSURANCE

The City will offer life insurance through UNUM for you. Your life benefits are an important part of the total Benefits Program package. Life insurance provides peace of mind knowing that your family will be taken care of in the event of an unexpected death. The City automatically provides regular, benefits eligible employees with Basic Life Insurance.

Basic Life and AD&D Insurance

In the event of your death, Basic Life and AD&D Insurance may be paid to your designated beneficiary in the amount of $50,000.

Your beneficiary is the person(s) who receives payment from your life insurance. You may change your beneficiary at any time.

Supplemental Life Insurance

In addition to the basic coverage provided by the City, you can elect to purchase higher amounts of coverage on yourself or voluntary coverage for your dependents.

You can elect coverage for yourself in increments of $10,000 up to a maximum of $200,000.

**Statement of Health -- A Statement of Health is required for supplemental life coverage if you elect after your initial eligibility period. Contact HR department for the appropriate form.*

IRS Rules: The IRS has issued regulations that limit the amount of tax-free group term life insurance to $50,000. This means that if the amount of Basic Life Insurance, plus the amount of Employee Supplemental Life Insurance you purchase is greater than $50,000, that value of your Life Insurance (as determined by the IRS based upon age) over $50,000 will be considered taxable income (the IRS calls this imputed income). A minimal tax will be assessed and will appear on your W-2.

Dependent Life Insurance

Supplemental Life insurance coverage is available for your spouse and eligible children. Coverage options are:

- **Spouse** - $10,000 increments up to a maximum of 100% of the employee's basic and supplemental amount combined up to $250,000. Any amounts equal to or greater than $30,000 require a Statement of Health.
- **Children** - $5,000 or $10,000

You are automatically the beneficiary for any dependent life insurance you elect.

You can elect spouse coverage up to 100% of your combined basic and supplemental life election. You, the employee, may elect supplemental life coverage for your dependents even if you do not elect coverage for yourself.

Your deductions for supplemental life insurance (if any) are made on an after-tax basis. This way, any benefits paid will not be subject to income taxes when received.

Supplemental and Dependent Spouse Life Rates

Monthly rates are based on the age of the employee as of January 1st or the effective date of coverage. Rates will change based on the schedule below.

Employee Age	Employee and Spouse Rates per $1,000
< 25	$.084
25 - 29	$.084
30 - 34	$.101
35 - 39	$.118
40 - 44	$.151
45 - 49	$.218
50 - 54	$.319
55 - 59	$.487
60 - 64	$.806
65 - 69	$1.310
70+	$2.218

To calculate your pay period deduction for supplemental life insurance, use the following formula:

Your Supplemental Coverage Amt ÷ $1,000 X Monthly Rate /2 = Pay Period Deduction

Dependent Child(ren) Life Rate

Dependent child(ren) coverage for $5,000 is $2.10 per month. Dependent child(ren) coverage for $10,000 is $4.20 per month. The rate for dependent child coverage covers all eligible children.

LONG TERM DISABILITY

The City automatically provides you with Long Term Disability (LTD) coverage at no cost to you, the employee. Your LTD coverage will be administered by UNUM.

LTD Benefits

Below is an overview of your benefits. Please see your Summary Plan Description for detailed information and definitions of your benefits.

LTD Benefits	
Eligibility	Full-time employees working at least 30 hours per week and actively at work
Monthly Benefit	60% to a maximum of $5,500
Minimum Monthly Benefit	$100
Earnings Definition	Gross monthly income before taxes, including overtime and any pre-tax contributions to a deferred compensation plan, excluding commissions, bonuses, or other extra compensation.
Elimination Period	90 days

SHORT TERM DISABILITY

The STD benefit is issued by UNUM. This benefit is designed to provide income to you and your family if you are unable to work for an extended period of time due to disabling injury or illness. Maternity benefits are also covered under this plan. STD coverage is completely voluntary and paid by the employee.

STD Benefits

An overview of your benefits has been provided. Please see your Summary Plan Description for detailed information and definitions of your benefits.

STD Benefits	
Eligibility	Full-time employees working at least 30 hours per week and actively at work
Weekly Benefit	60% to a maximum of $2,500
Minimum Weekly Benefit	$20
Earnings Definition	Gross weekly income before taxes, including overtime pay and any pre-tax contributions to a deferred compensation plan, excluding commissions, bonuses, or other extra compensation.
Elimination Period	30 days

STD Rates

The rate for the voluntary STD plan is $0.29 per $10 of elected weekly benefit. Your weekly benefit is provided to you on a tax free basis.

To calculate your pay period deduction for voluntary short term disability insurance, use the following formula:

Annual income / 52 weeks = weekly income. Weekly income X .60 (60% benefit) = weekly benefit. Weekly benefit / $10 =_____ x .29 = monthly cost

FLEXIBLE SPENDING ACCOUNTS

The City is pleased to continue to offer a Flexible Spending Account program to employees. The plan will be administered by UHC. The plan year will run January 1, 2011 through December 31, 2011.

The Flexible Spending Account (FSA) program will include a Health Care Expenses Account for your out of pocket medical expenses and a Dependent Care Flexible Spending Account for dependent care. FSA allows you to put aside money on a tax-free basis each pay period. When you have an eligible expense, you can submit a claim for reimbursement from your account.

How Can the Health Care & Dependent Care Spending Accounts Help Me?

Your Flexible Spending Account offers tax savings by allowing you to pay for qualifying out-of-pocket expenses with pre-tax dollars. Without a Flexible Spending Account, you would still pay for these expenses, but you would do so using money remaining in your paycheck after taxes are deducted.

Health Care Spending Account

By using pre-tax payroll contributions, you can receive reimbursement from your Health Care Spending Account for eligible medical, dental, vision and prescription expenses incurred by you or an eligible dependent, as long as the expenses are not covered or reimbursed by insurance or another FSA account.

You can use the account to receive reimbursement for health care related expenses such as:

- Deductibles, coinsurance, and copays
- Costs of eligible services above the reasonable and customary limits

Effective January 1, 2011, you may no longer use this account for over-the-counter health items.

Dependent Care Spending Accounts

To be eligible to use the Dependent Care Account, you (and your spouse, if married) must both work outside the home. You may claim dependent care expenses for a dependent that lives with you and relies on you for more than half of their support. You must claim the person as a dependent on your federal income tax return. Eligible dependents include:

- Children under the age of 13, and
- Disabled dependents of any age (such as your disabled spouse, older child, or parents)

What Type of Care is Covered?

You may only be reimbursed for day-care that enables you to work, not occasional baby-sitters. If you are married, your spouse must also work, be a full-time student or be disabled. Eligible care includes care in:

- Your home
- Someone else's home
- A licensed day-care facility

You may be reimbursed for care provided by a relative, as long as the person is not your spouse, a child under the age of 19, or someone you claim as a dependent on your federal income tax return.

What Happens if I Do Not Use All of the Money?

According to IRS regulations, any money left in your account which is not used for eligible expenses incurred by the end of the plan year must be forfeited. This is called the "use it or lose it" rule and it is the government's way of making sure you use the tax-free Spending Accounts as they were intended. As you consider the amount to put into your Spending Account, keep this "use it or lose it" rule in mind.

Use It Or Lose It!

You must incur eligible expenses during the plan year (January 1, 2011 – March 15, 2012) to receive reimbursement from the money you have contributed to the account(s). You will have until April 15 to file claims for expenses incurred during the plan year (January 1, 2011 – March 15, 2012. All money remaining in the account after that date will be forfeited.

Eligibility

All benefits-eligible employees working 30 or more hours per week are eligible to participate in either of the Flexible Spending Accounts. If you are not eligible or choose to waive coverage on January 1st, you may enter the plan on any subsequent January 1st, unless you have a qualified change in family status. If you experience a change in family status, please contact Human Resources. You have 30 days from the qualified change in family status to add or make changes to your election.

You **MUST** elect this benefit during enrollment each year to participate in the Flexible Spending Account program.

Maximum Contribution Amounts

The maximum contribution you can elect for the Health Care FSA is $3,600 and the maximum for the Dependent Care FSA is $5,000 per plan year ($2,500 if married filing jointly). The minimum that you can contribute is $120 per plan per year.

Reimbursement from Your FSA

In order to receive reimbursement from your FSA account, you must submit a claim form along with a receipt for an eligible expense to the plan administrator. You can also pay for qualifying medical and health expenses with a debit card.

When requesting reimbursement from your Dependent Care Account, you must provide the social security number of the individual caretaker or taxpayer I.D. number, name, address, and phone number of the day care facility.

For Dependent Care Accounts, you will only be reimbursed for the current amount available in your account.

Note: Amounts reimbursed through your dependent care FSA plan may not be used as a tax credit on your annual tax return.

If you file a claim instead of using your debit card, you can either receive your FSA reimbursement through direct deposit or check. You may sign up for Direct Deposit by going to www.myuhc.com and entering the appropriate account information.

How FSA Affects Income Tax and Social Security

FSA affects your taxable earnings for both Federal income tax and Social Security. Since you do not pay income tax on the portion of your salary used to pay for benefits under FSA, you cannot claim those amounts on your Federal income tax return at the end of the year.

Since you do not pay Social Security taxes on the portion of your salary used to pay for benefits under FSA, your participation may affect the benefits you and your family receive from Social Security when you retire. This difference is usually no more than a few dollars each month.

Your retirement plan contributions are based on your gross salary (your pay before taxes are deducted) and not affected by FSA. If you are near retirement, you should talk with a tax advisor to determine what is best for you.

2011 Holidays

The dates below are when the City observes these holidays and is closed for business:

- New Year's Day (Friday, December 31, 2010)
- Memorial Day (Monday, May 30, 2011)
- Independence Day (Monday, July 4, 2011)
- Labor Day (Monday, September 5, 2011)
- September 11th Holiday (Sunday, September 11, 2011)*
- Thanksgiving (Thursday, November 24, 2011)
- Day after Thanksgiving (Friday, November 25, 2011)**
- Christmas Eve (Friday, December 24, 2011)
- Christmas Day (Monday, December 26, 2011)
- New Year's Day 2012 (Monday January 2, 2012)

**Firefighters only*
***Except Firefighters*

Healthcare Reform: What's to Come

To help you gain some understanding of health care reform – and what it means in practical terms – we offer this summary of the legislation's impact as we understand it today.

If You Are Covered by the City's Health Plan

The legislation requires several plan changes to be implemented on January 1, 2011. These changes include:

- Pre-existing condition limits for children under age 19 are being removed
- Lifetime maximums on plan benefits are being removed
- Coverage for dependents will be extended to age 26
- Over-the-counter medications no longer qualify as eligible expenses for the Health Care Spending Account.

If You are Not Covered by a Medical Plan

Beginning in 2014, most individuals will be required to get health coverage or pay a penalty. Health insurance exchanges will be created to help people meet these individual responsibility requirements.

What Health Care Reform Means to You

The coverage improvements listed above may make our medical plans more expensive. There are a number of additional legislative provisions that may significantly affect our active and retiree medical plans in the future. Among the most prominent future changes:

- Annual benefit limits will be removed
- Health Care Spending Account contributions will be limited to $2,500 per year beginning in 2014 (The City currently allows you to contribute $3,600 per year)
- Pre-existing condition limits for adults will be removed
- Employees who meet certain affordability and income criteria can choose to use an employer-provided health care voucher to opt out of the City's plan and purchase coverage through a state-run health insurance exchange

What's Next

Despite the passage and signing of health care legislation in Washington, many implementation issues remain unclear. Health care reform will continue to evolve. The interpretation of these laws may change prior to implementation. We are committed to keeping all our City employees and retirees fully informed as the implications of health care reform become clearer over time. As always, we will share with you more information as it becomes known.

IMPORTANT NOTICES

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the City of Frisco group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the City of Frisco has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the City of Frisco within 31 days after the qualifying event occurs.

How Is COBRA Coverage Provided?

Once the City of Frisco receives proper notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the City of Frisco in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the City of Frisco. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the City of Frisco informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact City of Frisco's Human Resources at 972-292-5200 for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

MEDICARE PART D NOTICE

Important Notice from City of Frisco About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Frisco and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Frisco has determined that the prescription drug coverage offered by the City of Frisco Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Frisco coverage will be affected. For those individuals who elect the Blue Cross and Blue Shield medical and prescription drug plan, the coverage is creditable so you would not need to enroll in a Medicare Part D plan, as the two plans would coordinate benefits with the City plan being primary and the Part D plan never paying any benefit.

If you do decide to join a Medicare drug plan and drop your current City of Frisco coverage, be aware that you and your dependents will be able to get this coverage back during a future open enrollment period, assuming you are still actively employed by the City of Frisco.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Frisco and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable

coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Frisco changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

a. Visit www.medicare.gov.

b. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

c. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.

Health care operations mean such business-related activities as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.

We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Office for Civil Rights.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

WHCRA NOTICE

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains the most important provision of the Act. Please review this information carefully. If you or your spouse is covered under the Medical Plan, please make certain that he or she also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for any complication in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the plan. The coverage may be subject to annual deductible and coinsurance provisions.
The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirement of the Act;
- Penalizing, reducing or limiting reimbursement to the attending provider (e.g., physician, clinic or hospital) to induce the provider to provide care inconsistent with the Act; and
- Providing monetary incentive to an attending provider to induce the provider to provide care inconsistent with the Act.

The Women's Health and Cancer Rights Act of 1998 will apply to the Health Plan on the effective date of your coverage.

OTHER IMPORTANT NOTICES

HIPAA NOTICE

If you were covered under a prior qualified plan and have lost coverage no more than 63 days prior to the effective date of this plan, you may be eligible to have all or part of the pre-existing condition limitation waived. You must provide United Healthcare with a *Certificate of Creditable Coverage* from your prior qualified insurance plan.

Patient Protection Disclosure

United Healthcare generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact United Healthcare at 1-800-842-5658.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact United Healthcare at 1-800-842-5658.

Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under United Healthcare no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact United Healthcare at 1-800-842-5658.

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in United Healthcare. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to November 1, 2010. For more information contact United Healthcare at 1-800-842-5658.

For Those Age 50 or Older

Senate Bill 1467 requires benefit plans that cover screening medical procedures to pay for colorectal examinations for enrollees who are age 50 or older and at normal risk for developing cancer of the colon. Your benefits are:

- An annual fecal occult blood text and a flexible sigmoidoscopy every five years, or
- A colonoscopy every 10 years.

Newborn's and Mother's Health Protection Act (NMHPA)

The Newborn's and Mother's Health Protection Act (NMHPA) restricts limiting the length of a hospital stay in connection with childbirth for a mother or newborn child to less than 48 hours (or 96 hours for a cesarean delivery). The law does not prohibit earlier discharge if the mother and her attending physician are in agreement that an earlier discharge is appropriate. In addition, authorization of the hospital stay cannot be required for stays of 48 hours or less (or 96 hours) nor are early discharge incentives allowed. Hospital stays begin at delivery or upon hospital admission (whichever is later).

Grandfathered Health Plan Notice

The City of Frisco believes the PPO medical plans are a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator with Human Resources.

Certification of Other Comparable Coverage
Opt-Out of Medical Coverage

Instructions

1. Please print clearly.

2. Attach proof of other comparable medical insurance coverage that shows you as a covered member (ID card, letter from insurance company, copy of enrollment information.) Dates must be included and coverage is subject to verification.

3. Return this form and proof of other comparable medical coverage to your Human Resources Department by the applicable deadline.

4. Check one box only and provide the dates requested.

☐ New-Hire
Hire Date _____
Due within 14 days of hire date.

☐ Annual Enrollment
Due on or before November 30

☐ Qualified Change in Status Event
Event Date _____
Notification Date _____
Opt-Out begins 1st of month following notification date; notification must be provided within 31 days of the event.

_____ _____
Last Name First Name

_____ _____ _____
Social Security Number Office Telephone Email Address

_____ _____ _____ _____
Home Address City State Zip

I elect to opt-out of my Employer's sponsored medical plan. This opt-out election is subject to the provisions of my Employer's Cafeteria Plan, benefit plans and personnel policies. Any reference to "other coverage" means "other comparable coverage" and generally refers to another employer's group health plan (typically spouse coverage), and does not include Medicare, Medicaid, a student health plan, or coverage which is not comparable. I have been given an opportunity to ask questions about the opt-out election and understand and agree to all of the conditions listed below.

1. My Employer can disregard this form. If my Employer has reason to believe this Certification is incorrect, invalid, or that I do not have other comparable coverage, my Employer reserves the right to disregard this Certification. My employer can request proof of other comparable coverage at any time.
2. I cannot change this election unless specific circumstances apply. Once I opt-out of medical coverage, the election cannot be changed until the next annual enrollment period unless I experience a Qualified Change in Status Event. If I experience a Qualified Change in Status Event, I can make a new election for medical coverage as long as the election is consistent with the Qualified Change in Status Event.
3. I must turn in my documents before the deadline. My Employer must receive this signed Certification and proof of other comparable coverage, no later than the applicable deadline described above. The information is considered received by my Employer when received by my Employer's Human Resources Office.
4. If I do not turn in my documents on time, I cannot elect opt-out, even if I have other comparable medical coverage. If I elect to opt-out of my Employer's sponsored medical plan but fail to provide the signed Certification of Other Comparable Coverage Form and valid proof of other comparable medical coverage by the date due, and:
    - I am a newly-hired employee, I will be enrolled in my Employer's designated default election plan, employee coverage only (no dependent coverage); or
    - I am currently enrolled in my Employer's medical plan, then this opt-out election is considered void and I will remain enrolled in the plan and coverage level in force as if this election was not made, subject to the terms of the underlying plans.
5. If I opt-out, I am considered absent from my Employer's medical plans. Therefore, I am not eligible for continuation of medical coverage (COBRA).
6. I am not required to provide insurance coverage to dependents under a court order. I further confirm I am not required to provide insurance to dependents under a Qualified Medical Child Support Order (QMCSO.)
7. It is my responsibility to notify my Employer within 31 days of the date my alternate medical insurance coverage ends. If I fail to do so, I acknowledge I may be enrolled in my Employer's designated default election plan, employee coverage only, and I authorize payroll deductions for any premium due. I further acknowledge I may not be eligible to enroll in the Employer sponsored medical plan of my choice until the next annual enrollment period.

Signature

I certify that I am covered by other comparable medical insurance coverage from a source other than my Employer and agree to comply with the conditions as described above.

_____ _____
Signature Date

BENEFIT CONTACT INFORMATION

Did you know that you can choose a provider…verify plan benefits…request an ID card…file a claim, just by making a phone call to your plan administrator?

City of Frisco Contact Information

Who to Call	For Information On	Contact Information
Human Resources	• Questions on any of the benefits offered by the City • Change in family status, address change • Request of ID cards for all benefits programs • Any claim issues you cannot resolve with the carrier direct • Prescription drug benefits	Becky Taylor, Benefits Manager 972.292.5203 Pamela Hayward, HR Analyst 972.292.5207 Gloria Martinez, HR Generalist 972.292.5209 Jonette Lingenfelder, HR Generalist 972.292.5205 Shannon Allyn, HR Generalist 972.292.5206 Lauren Safranek, Director of HR 972.292.5210 Website: http://www.friscotexas.gov/departments/humanresources/Pages/OpenEnrollment.aspx

Carrier Information

Benefit Plan	For Information On	Contact Information
Medical Carrier United Healthcare (UHC)	• Plan benefits, eligibility, preferred providers, claim status, covered medical services, ID Cards • To request pre-certification of a hospital stay or surgery, authorization and referral for mental health and substance abuse treatment • Prescription drug benefits • www.myuhc.com gives the employee access to personal information including, but not limited to claim status, temporary ID cards, etc.	1-800-842-5658 www.myuhc.com
Employee Assistance Program (EAP) **UNUM**	• To discuss personal, work, legal, or financial issues	1-800-422-5142 (English) 1-877-858-2147 (Spanish) www.lifebalance.net ID= unum password= lifebalance
Dental DHMO Carrier **Assurant Employee Benefits**	• To locate participating providers	1-800-443-2995 www.assurantemployeebenefits.com
Dental DPPO Carrier **Delta Dental**	• Benefits, eligibility, claim status • To locate participating providers	1-800-521-2651 www.deltadentalins.com
Vision **VSP**	• Benefits, claim status, participating providers	1-800-877-7195 www.vsp.com
Life/AD&D **UNUM**	• Basic Life and AD&D • Supplemental Life and AD&D • Dependent Life	1-800-445-0402
Long Term Disability **UNUM**	• To file a claim	1-800-633-7479
Short Term Disability **UNUM**	• To file a claim	1-800-633-7479
Flexible Spending Account **UHC**	• To file a claim	1-800-842-5658 www.myuhc.com

Keep this contact sheet for future use!

NOTES

The City of Frisco

2011 Employee Benefits Guide